

A Pilot Method for Multimodal Group Therapy for Adults with ADHD

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Abstract:

The management of ADHD across the lifespan is a topic of scientific and public debate, with much discussion centering on optimal treatments. Increasing empirical evidence suggests that successful management of ADHD involves a combination of stimulant medication and psychosocial interventions. This article describes an original approach combining multiple psychotherapeutic modalities that addresses the complex treatment requirements of adult patients with ADHD, through a structured, integrative, psychosocial therapeutic model that holistically encompasses problematic aspects of life for the adult with ADHD. This model integrates a range of methods, including, problem-solving therapy, mindfulness, cognitive-behavioral therapy (CBT) and family therapy. Each of these methods have previously been empirically proven to be effective for this patient population, but have never been integrated into a coherent intervention comprised of group work designed for problem identification, positive reinforcement and modeling, peer discussions aimed to facilitate anger expression, communication and assertiveness training, and mindfulness and CBT exercises for increased awareness and organization, and to support new solutions for identified problems. Patients are also encouraged to identify trans-generational interaction patterns, reflect on how these patterns impact their emotional difficulties, and eventually achieve enhanced self-acceptance.

Key Words: multimodal group therapy, mindfulness, cognitive behavioral therapy, problem solving, adult attention-deficit hyperactivity disorder.

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Attention-deficit hyperactivity disorder (ADHD) is a neurobiological disorder that emerges in childhood and may persist into adulthood, having a major impact on the patient's functionality (Biederman et al., 2006). Follow-up studies with adults show that prominent symptoms and impairment related to the disorder continue into adulthood in about 50% of the cases (Barkley, 2003). This condition is estimated to affect up to 4.4% to 4.7% of the general adult population

(Kessler et al., 2006; Kooij et al., 2008). Most adults manifest a symptomatic persistence resulting from unsuccessful attempts to cope with primary symptoms appearing in childhood. The core childhood symptoms shift with development, and culminate towards difficulties with self-regulation, leading to the inability to successfully carry-on responsible and independent living (Wasserstein, 2005). In addition, adults with ADHD tend to present with multiple comorbidities, which add to clinical severity and functioning difficulties. Most of these patients struggle with a broad range of functional impairment throughout their lifespan (Harpin, 2005; Wilens & Dodson, 2004).

The management of ADHD across the lifespan is a topic of scientific and public debate, with much discussion centering on optimal treatments (Greydanus, Pratt & Patel, 2007; Greydanus, Pratt, Sloane & Rappley, 2003). Untreated ADHD has a sizeable impact at all ages (Kessler et al., 2006; Swensen et al., 2003), and research is required to validate optimal management strategies that would comprehensively address the multiple areas of functioning affected by this condition.

Although pharmacological treatments with stimulant medication may contribute to the reduction of about 50% of the core symptoms (Safren et al., 2005; Wilens, 2002), they do not fully address the multiple domains of impairment identified in adults with ADHD (Knouse, Cooper-Vince, Sprich & Safren, 2008). Furthermore, some of these patients are ambivalent about the pharmacologic treatments prescribed for ADHD as they may cause significant side effects and do not completely resolve the consequences of carrying forward the associated symptoms and dysfunctions throughout their lives. Increasing empirical evidence suggests that successful management of ADHD involves a combination of stimulant medication and psychosocial interventions (Safren, Sprich, Chulvick & Otto, 2004); and, in fact, American, Canadian and British practice guidelines recommend that both pharmacologic and non-pharmacologic treatment should indeed be combined (Gibbins & Weiss, 2007).

Particular psychosocial treatment modalities have already been proven to be effective for adult patients with ADHD. Solanto, Marks, Mitchell, Wasserstein & Kofman (2008) designed a treatment program for adults with ADHD based on a cognitive-behavioral therapy model. In 2010, Solanto, Marks & Wasserstein published data regarding the efficacy of this meta-cognitive therapy. In this approach, the cognitive and behavioral interventions were shown to potentiate each other: a more efficient and organized behavior helps establish more positive cognitive assumptions, while more adaptive cognitions facilitate improvement in behavioral organization. Smalley et al. (2009) and Zylowska et al. (2008) established a different modality, combining mindfulness-based stress reduction (Kabat-Zinn, 1990) with mindfulness-based cognitive therapy (Segal, Williams & Teasdale, 2002), which led the way to the development of the mindful awareness practices (MAPs) for ADHD. Approaching treatment from a different perspective,

Everett & Everett (1999) applied family systems therapy to help individuals with ADHD resolve interpersonal and family conflict.

Patients with ADHD present with a combination of symptoms and dysfunctions due to multiple comorbidities and usually experience a long-standing disappointment with themselves. Initial results from small-scale studies of manualized therapies in different modalities offered alongside pharmacotherapy are showing encouraging results. However, the patient study samples are small and highly selective, and no superiority studies demonstrating which methods work best have been conducted to date. A psychosocial approach consisting of one specialized modality may not efficiently address the complex functional impairment displayed by these patients. The following example describes an original approach combining multiple psychotherapeutic modalities aiming to adequately cover the complex needs of adult patients with ADHD and comorbid conditions.

Preliminary Considerations for a Pilot Approach – Treating Adults with ADHD in a Group Setting

The impact of ADHD symptoms is systemic. For these patients, the overall functioning within human systems is significantly impaired due to executive functioning limitations that profoundly affect their capacity to coordinate their inner world and their relation with the environment. These patterns of dysfunction are pervasively influenced by a lifetime failure to perform accurately, which further influences the sense and value of the self. Group interventions address systemic deficits of functioning and allow social reinforcement of new behaviors. Psychosocial interventions within a group setting are expected to be the most successful for adults with ADHD (Hesslinger et al., 2002; Philipson et al., 2007; Safren et al., 2005), as they create the ideal milieu for social support and positive modelling. Adults with ADHD often feel inadequate and defective. Undergoing therapy within a group environment among peers who mutually support and encourage one another, and which promotes the open exchange of information and education, provides these patients with a sense of validation, and helps to reduce these feelings of defectiveness and inadequacy (Murphy, 2005). Groups consisting exclusively of adult patients with ADHD may offer vivid settings in which patients who share similar symptoms and problems feel understood. As such, they are willing to self-disclose and receive feedback, thus succeeding in correcting a system of maladaptive beliefs and behaviors. In such psychopathological homogenous groups, these individuals can learn from each other how to cope with similar symptoms and acquire information to modify their dysfunctions. Overall, the group setting fosters the realization of extended commonalities and supports self-validation and acceptance.

As most patients with ADHD experience increased social anxiety, the social nature of the groups provides these patients with opportunities to examine their

difficulties in a network where they are not much different from one another with regard to their competence. Furthermore, by lending patients the opportunity for observational learning and offering them modeling opportunities, the group setting creates an environment in which the patients' understanding of the disorder becomes integrated with that of the group facilitators'. Increasingly, each patient is enabled to take on a therapeutic role within the group, thereby increasing their autonomy (Bateman, Brown & Pedder, 2010). Tendencies towards treatment-fostered dependency are minimized within the group therapy setting, as a therapeutic alliance is forged, not only with the therapist(s), but also with fellow patients. The patients learn a lot about themselves from the feedback they receive from the therapist(s), as well as from their peers within the group. The group setting may, therefore, help enhance patients' awareness of both their strengths and weaknesses.

How to Integrate Modalities within the Group Setting

Previous research on ADHD among children has shown psychosocial approaches in integrated modalities to be superior to those interventions offered in a single therapy modality (Murray et al., 2008). Norcross & Beutler (2008) viewed "rivalry among theoretical orientation" and neglect of "alternative conceptualizations" to be therapeutically counter-productive, favoring instead an openness to diverse theories and techniques with the ultimate goal of integration in order to enhance treatment efficiency. Integrative psychotherapy approaches (Norcross & Beutler, 2008; Tuckman, 2007; Holmes & Bateman, 2007) transcend the limited applicability of single-theory methods and offer a conceptual framework that selectively incorporates the most adequate interventions in accordance with particular psychopathological aspects. This combines the advantages of a single coherent theoretical system with the flexibility of a variety of interventions from multiple modalities. Altogether, psychotherapy integration is meant to look across the confines of single-school-of-thought approaches to see what can be learned from other perspectives. Multimodal treatment refers to fashioning a collection of treatment modalities in order to provide specialized support in the specific areas of life that are most problematic for each individual in the group (Ramsay & Rostain, 2008). The majority of research conducted to date regarding psychosocial interventions for adults with ADHD has explored single modality treatment, with only a few studies (Jacob, Philipsen, Ebert & Deckert, 2008; Murphy, 2005) having examined multimodal approaches.

Adults with ADHD present lifetime symptoms that may lead to a significant degree of impairment in their relational and instrumental functioning, thereby creating significant problems for them. The identification and correction of these problems will ultimately lead to reduction of the dysfunction. Problem-solving therapy is conceived as a conscious, effortful and purposeful activity (D'Zurilla & Nezu, 2007) meant to find a solution to a specific problem. It aims to change the problematic situation for the better, thereby reducing the emotional distress that it

produces (D'Zurilla & Nezu, 2007). When patients identify a problem, their awareness of the problematic context is enhanced. They also commit time and effort towards developing the skills required to implement a solution to their problem. Ultimately, successful problem-solving leads to improvement in self-efficacy, as patients experience an enhanced sense of control over their particular problem or situation.

For adult patients with ADHD, psychosocial interventions based on problem-solving strategies are expected to raise the desire for change, and thus improve therapeutic compliance. By identifying a problem, such as having low self-acceptance, always being late for work, being distracted at work, not finishing tasks, poor time management, missing deadlines, or being angry all the time, and then choosing to solve it, patients are able to visualize clear, long-term rewards, thereby remaining motivated throughout the therapeutic intervention. The recognition of a problem may also give the patient the feeling of self-initiating the therapy, thereby giving them a better sense of control over the entire process. The role of the patient within a group setting is to take ownership of their own problem or situation, and to actively seek a solution, which, in turn, may encourage them to enhance their assertiveness.

Psychosocial therapy in a group setting can serve as an excellent training milieu for individuals with interpersonal difficulties. As the patient increasingly opens up to the group about their problems, they become more and more responsive and involved with the other participants (Bateman et al., 2010). Group members may provide one another with focused support and advice, thus participating in creating the experiences unfolding within the group, as well as reflecting upon and responding to these experiences. In doing so, they may eventually be able to put into words what was previously unknown or inexpressible to themselves and/or to others. This problem formulation helps orient the group therapy process towards tasks and goals. Despite the heterogeneity of ADHD, these groups for adults with the condition can be quite homogenous with regard to their therapeutic goals, thus enabling the group to clearly define these goals. For the implementation of the chosen solution, however, the patient would need to develop complimentary skills. A multimodal approach can better satisfy the needs of these complex therapeutic requirements.

Typically, patients with ADHD present difficulties with attention and awareness. Mindfulness-based therapy may help adult patients with ADHD become more aware, in a mindful way, and improve their capacity to focus their attention. Initiated as an intervention on self-directedness (Smalley et al., 2009), mindfulness training may help shift the patient towards increased awareness of an abstract concept, such as time. Empirical research supports the assumption that mindfulness training can modify attentional networks (Jha, Krompinger & Baime, 2007), and demonstrates good results for mindful meditation for adults with ADHD (Zylowska et al., 2012). A feasibility study (Zylowska et al., 2008)

supports improvement of attention and emotion regulation in patients receiving this intervention, and encourages future controlled studies on this path.

Enhanced awareness facilitates the work on counterproductive cognitions and organization. Cognitive approaches for patients with ADHD have been extensively prescribed (Ramsay & Rostain, 2008; Solanto et al., 2008, 2010). The cognitive interventions start working once the diagnosis is accepted, and the patient becomes aware of the symptoms and functional consequences of this condition.

As the impact of the ADHD symptoms is systemic, it threatens the family homeostasis across generations. Patients with ADHD are usually caught in vertical loyalties which mask latent anger and unsolved emotional needs. They often present individuation difficulties and dependency, which are reinforced transgenerationally (Everett & Everett, 1999) and perpetuate low self-esteem. This counteracts the development of executive self-management, thus aggravating the biological deficit. Systemic interventions are also recommended in adult patients with ADHD, as they can complement mindfulness and CBT by supporting adult patients with ADHD in their goal to reach a healthy control over their emotions and thoughts, and improve self-management.

Based on previous evidence, we have implemented a structured, integrative psychosocial treatment model meant to provide support in all specific areas of life that are problematic for the adult individual with ADHD. Such an approach holistically encompasses individual needs by connecting methods from problem-solving therapy, mindfulness, CBT and family therapy. Although each of these methods has previously been empirically proven to be effective for adults with ADHD, they have never before been integrated in a coherent intervention.

A Structured Multimodal Model for Group Therapy with Adults Diagnosed with ADHD

We are currently offering an unprecedented approach to group therapy for adults with ADHD at the *Adult Mental Health Program* in Kingston, Ontario, Canada. All the participants within these groups meet the diagnostic criteria for ADHD according to the DSM-IV-TR—the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders, Text Revision* (American Psychiatric Association, 2000) (see Table 1), and had already been initiated on pharmacotherapy upon enrollment. Each group consists of 6-8 individuals aged 18-65 years. Individuals with comorbid conditions, such as depression, anxiety, bipolar disorder, and post-traumatic stress disorder (PTSD), are not excluded from participating. However, patients with severe concomitant substance addictions and/or severe personality disorders that are likely to present in the group with disturbing behaviours are excluded. All diagnostic decisions are made in accordance with the fourth edition of the *Diagnostic and Statistical Manual of*

Mental Disorders, Text Revision (DSM-IV-TR) (American Psychiatric Association, 2000). Each session is facilitated by one therapist.

Description of the Group Sessions

The intervention consists of ten sessions of structured, integrative, multimodal group therapy, within which the facilitators apply a variety of psychotherapeutic approaches, including the problem-solving approach promoted by D'Zurilla & Nezu (2007), the mindfulness interventions promoted for adults with ADHD by Zylowska (2012), the cognitive-behavioural approach promoted for patients with ADHD by Solanto et al. (2008, 2010), and a systemic perspective on families with ADHD by Everett & Everett (1999).

Lazarus (1989) described the stability of the treatment outcome as being closely tied to the thoroughness with which specific problems are systematically resolved. This is the basis of our overall approach with this program; an approach that is both problem-centered and goal-oriented, with an initial focus on psycho-education and the clarification of the symptoms and dysfunctions related to ADHD. During the program's ten sessions, each participant is encouraged to identify their key problems, and then guided and supported in dismantling their complex tasks and problems into smaller, more manageable parts. The facilitators then introduce to them various therapeutic tools to help them solve these problems, and provide ongoing support to cognitively facilitate and reinforce the patients' commitment to change. The patients are also introduced to strategies to help them acknowledge and deal with counter-productive emotional responses, feelings of self-blame, low self-esteem and lack of self-acceptance. In doing so, we anticipate enhancing the patients' effectiveness in:

- solving a clear problem;
- identifying the source of failure and avoid it;
- identifying roadblocks to recovery;
- stimuli control;
- managing difficult tasks;
- avoiding dependency and over commitment;
- developing routines, and;
- maintaining structure.

The end goals are for the patients to reconceive their own identities in light of having ADHD, to become aware of the strengths they have gained from their condition, and to take an active role in their change, thereby resulting in an

eventual improvement in their overall functioning and self-esteem, and an instilled sense of hope.

Session 1. During the first session, patients and facilitators introduce themselves and share their understanding regarding the diagnosis of ADHD. The group facilitators provide education regarding the symptoms and functional limitations of adult ADHD. Understanding and accepting the diagnosis is crucial for adult patients who have lived their entire lives with the shame of not being able to succeed and with the guilt of not being able to fulfill expectations. Accepting the diagnosis is the most important premise for changing unproductive defenses and committing to growth.

After theoretical and practical matters regarding the presentation and impact of adult ADHD are clarified, each participant is asked to identify the chief problem that they currently attribute to their condition. As they do so, we observe that group participants become quite sympathetic with each other as they recognize in one another a difficulty that they themselves have struggled with for a long time, and are subsequently happy to share their best approach to dealing with that difficulty. ADHD peers facilitate alternative solutions to each other's chief problem and are able to predict consequences. Peers who have succeeded in managing similar problems instill hope and a positive attitude towards the possibility of solving the problem, or, at least, towards coping with it. At the end of this session, each participant is encouraged to develop a plan for solving their problem, and to formulate realistic goals. Patients are informed that, during each of the next few sessions, discussions will focus on solutions to help them implement their problem-solving plans, and on the potential roadblocks they might encounter. They will be encouraged, throughout the rest of the therapeutic program, to find and apply solutions for solving their main problem.

Sessions 2-7. Over the course of the next six sessions, new tools are progressively presented to the patients and incorporated into their individual problem-solving plans. By simply identifying their problem and taking on the responsibility of resolving it, the patients become engaged in a process of self-assessment (Nezu, Nezu & D'Zurilla, 2007), and start evaluating their strengths and weaknesses. This opens the path towards the attainment of self-insight and self-control, which will be facilitated during subsequent sessions by combining the practice of mindfulness exercises with cognitive behavioral work.

Mindfulness may be a very helpful tool to better understand and manage the symptoms of adult ADHD (Zylowska, 2012). In an article published in 2003, Kabat-Zinn describes mindfulness as “the awareness that emerges through paying attention on purpose, in the present moment, and non-judgmentally to the unfolding of experience moment by moment.” In another publication, Bishop *et al* (2004) recognize the contribution of mindfulness experience in improving self-regulation, while Dorje (2010) identifies five dimensions of mindfulness: intention

and context of mindfulness practice, bare attention, attentional control, wholesome emotions, and ethical discernment, with two additional factors—meta-awareness and insight. Zylowska (2010, 2012) has masterfully adjusted the practice along these dimensions to the treatment needs of adult patients with ADHD. In our groups, we use her materials unmodified.

Mindfulness as a treatment modality for adults with ADHD is introduced to the group in Session 2 via the 7-minute exercise, "My ADHD" by Zylowska (2010), whose impact both the group members and facilitators subsequently reflect on. Complementing this is the "Attention, Executive Function, Emotion Regulation" exercise (Zylowska, 2010), which we use to further demonstrate these concepts. At the end of the session, we introduce the "Mindful Breathing" exercise (Zylowska 2012), which patients are encouraged to practice at home on a daily basis.

At the beginning of each subsequent session, peers and facilitators discuss impressions and difficulties related to practicing the given homework on mindfulness. Patients are also asked to comment on how the practice of mindfulness may have helped them find solutions to their problem, and/or helped them overcome any difficulties they may have had in implementing these solutions in daily life. At the start of each session, group members are also asked to describe any roadblocks that may be preventing them from solving their problem, and to discuss alternative solutions. The practice of the exercises "Mindfulness of Sound-Breath-Body" and "Mindful Presence" are also introduced to the group members, who are asked to practice them at home on a daily basis. During these exercises, patients intentionally pay attention to their breath and body or to their environment and at the same time identify possible distractions. In doing so, they become aware of the change in the flow of experience within and outside of themselves. (Zylowska, 2012). The patients are also encouraged to expand their mindful awareness to aspects related to the problem they identified in Session 1.

By this point in the therapeutic program, it is expected that the patients have already achieved some improvement in control over their awareness, and have progressed in their capacity to reflect upon it. Therefore, we shift our focus specifically on improving the patients' awareness of the concept of time. Adults with ADHD present difficulties with regard to time awareness, which leads to problems with time management. They tend to have more trouble tracking the passage of time and adjusting their activities accordingly. Furthermore, they make more errors estimating how long things actually take, and therefore do not allow sufficient time to complete tasks in their home, work and personal life. Mindfulness intervention focused on increasing self-directedness and mindfulness training may facilitate the shift to increased awareness of an abstract concept such as time (Solanto, 2011; Zylowska, 2012). The cognitive approach recommended by Solanto (2011) for tracking daily events and prioritizing is added to the exercises practiced in class and as homework. The discussion is

centered on time management and the use of tools, such as personal planners or watches, to improve the awareness of time. Interestingly, we have noted that many of the participating adult ADHD patients do not wear a wrist watch, and many do not, or have never, possessed one. We encourage our patients to incorporate these tools into their daily activities, and to apply them to their problem-solving strategy.

We also use Solanto's (2011) example for the "Importance-Urgency Grid", including the in-class exercises and the recommended homework for prioritizing and generating a to-do list. During the in-class exercise, we observed that patients tended to list the activities that are most pleasurable for them as non-important and non-urgent. We suggested that they periodically prioritize such activities, in order to maintain a healthy balance between "pleasant" and "less pleasant" events.

Given their difficulties with time management, patients with ADHD are usually less aware than the average person when there is insufficient time to complete all the tasks they have planned. They internalize guilt and shame for not accomplishing enough, and cannot recognize the fact that their list of tasks may be too complex. They are usually unaware that they are unable to limit their list of tasks, and that they are taking on every new task that seems interesting to them. As described by Solanto (2011), patients with ADHD will respond in the moment. During our sessions, participants find the practice of prioritizing their tasks and breaking them into manageable parts very useful (Solanto, 2011). Each patient is encouraged to give an example of a project they had trouble starting and completing. They are then asked to work together to find the most effective way to break down each other's individual tasks into smaller, more manageable parts. Their mutual cooperation and the efficiency with which they complete this exercise have exceeded our expectations. To help them apply this tool in their everyday lives, we initiated a personal reward list for each patient and encouraged them to complete it at home. The group of participants are also introduced to the mindfulness exercise "Stop Practice" (Zylowska, 2010), and are encouraged to continue practicing this exercise as homework. In the "Stop Practice", patients must pause and observe in order to become more aware of the present moment. This allows them to step out of their usual "automatic pilot" mode and note their experienced feelings, sensations or level of energy. They may choose to continue what they were doing or redirect their attention to prior intentions.

As they reach Session 6, patients begin to report success in implementing their goals. Although they do not find this to be an easy task, they do find it intriguing and arousing, which motivates them to work well on their assigned homework. The overall feeling of satisfaction at the end of the day after accomplishing good results for their most important and pressing tasks is extremely rewarding for the patients, and clearly increases their motivation for change. They report

improvement with regard to time awareness, capacity to manage time, and the ability to complete complicated tasks.

In Session 6 we address sensory and social distractions and implement the educational approach suggested by Solanto (2011). For the in-class exercise, the patient is asked to devise a system for organizing the clutter in their home or work space and then to divide the task into parts. Emotional roadblocks that could interfere with the patients' recovery, such as feelings of hopelessness or fear of failure, are taken into consideration.

In its general acceptance, mindfulness is meant to correct destructive emotions, and "to mitigate the enormous personal and societal harm that so often stems from them" (Kabat-Zinn, 2010). Individuals with ADHD often present irrational core beliefs about themselves that may result in anxiety and depression. Cognitive distortions and automatic negative beliefs have been flagged in adult patients with ADHD and have been identified as emotional distracters to successful self-management (Solanto et al., 2008; Solanto, 2011). As such, at this particular stage of the group sessions, patients are asked to reflect on how their negative feelings trigger automatic distorting thoughts, thereby maintaining a vicious cycle of negative thinking, feelings and behavior. Although the mindfulness exercises assigned to the patients in previous sessions greatly facilitate the awareness of their feelings, at this point in time, the mindfulness exercises known as "Labeling" are also introduced to the group (Zylowska, 2010). During the "Labeling" exercise, patients are asked to name inner experiences, like thoughts, worries, feelings and body sensations, with the purpose of better managing them. Labeling helps bring the patient's wandering attention back to what was intended to be done.

The patients are encouraged to generate alternative scripts based on Solanto's (2011) "In-Class and Take-Home Exercise" as a way of challenging the negative, automatic thoughts previously identified.

Session 8-9. Session 8 begins with the "Loving Kindness Meditation" part of Zylowska's (2012) mindfulness intervention, intended to facilitate our patient's awareness of positive feelings. Following this exercise, we discuss with the patients how they accomplished their homework. We address the obstacles they encountered with regard to practicing better control over their automatic, negative thoughts, and to implementing new solutions to their problems.

It has been previously shown by Everett & Everett (1999) that cognitive distortions and automatic, negative patterns of thinking develop early in childhood in relation to systemic family interactions. The family's reciprocal attitudes and responses toward the ADHD member may cause reciprocal responses of frustration, anger and embarrassment by parents and siblings, leading to the perpetuation of negative emotions and congruent cognitions.

Dependency and immaturity are often reinforced in these patients by intergenerational interactions. Furthermore, transgenerational dynamics in families with ADHD patients maintain dysfunctional patterns (enmeshing and disengaging systems) that reinforce low self-esteem in these patients beginning in childhood. These children grow up with a pervasive sense of guilt and personal failure that enable cognitive distortions. Both facilitators and patients should be able to recognize and understand how these circular and reciprocal responses have influenced the patient's emotional and cognitive development.

The goal of this particular session is to open up discussions regarding familial, transgenerational, dysfunctional patterns. Such models of interaction are identified by each patient by using genograms. They are able to recognize and reflect upon persistent models of poor parental control and interaction, marital conflict, inadequate and/or reactive parenting, sibling conflict and rejection, familial attitudes for educational failure, and poor modeling for social skills and personal decision making. All the patients express interest in uncovering dysfunctional family patterns while completing the genogram. During this session, patients are able to identify the impact that their own emotional instability can have on family functioning. They recognize how it can be the root cause of their main problem, whether it is low self-acceptance or "being angry all the time", and how it can act as a roadblock to resolving their main problem.

Systemic interventions are, therefore, a very important component of our psychotherapeutic approach to treating adult ADHD patients. Everett & Everett (1999) noted that adults with ADHD tend to attach an emotional and dependent manner to families of origin. This dependency characteristic formulates latent anger and unresolved emotional needs for the patient that results in a stronger vertical loyalty. As adults, these vertical loyalties to their family of origin create dysfunction, which in turn, has a direct negative impact on their horizontal relationships with their partners. By looking at their genograms, the participants are able to enhance awareness of their family relationships and identify the powerful impact these interactions can have on their own autonomy. This exercise allows them to reflect on the underpinnings of their irrational core belief system, thereby enabling them to model new behavior's towards their families and break the transgenerational cycle. Peer discussions held during these sessions support each participant's capacity to deal with and assert these patterns, and help them foster their individual capacity to reflect upon their preference for negative automatic assumptions. At the end of session 9, the group is introduced to "Mindfulness in Everyday Life" (Zylowska, 2010), an exercise that encourages patients to bring attention to the present moment anywhere, anytime, and in all aspects of the day-to-day life, including work, relationships, times of difficulty, and times of joy. All the patients are advised to practice it as homework.

Session 10 – Wrap Up. During Session 10, participants are asked to discuss their therapeutic experience, and to critically analyze their

progress in implementing successful solutions in order to solve the problem identified in Session 1 and continuously addressed during subsequent therapy sessions. The overall impression is that, by identifying the main problem at the beginning of the group therapy sessions and using it as a pivotal context for learning and applying new skills, the coherence of the process is increased and the patient's motivation to participate is better maintained. The participants express an appreciation of the integrative, multimodal therapeutic approach, as it comprehensively addresses the multi-faceted impact of ADHD on their lives. At the end of the therapy, patients claim that the treatment was effective in reducing the intensity and significance of their symptoms. They appreciate that their symptoms have diminished, and that their overall functioning has improved to some extent. Within the group setting, patients appear to be very comfortable with each other. They are able to provide each other with mutual support and encouragement.

Conclusion

In summary, the experience of facilitating several groups in a highly-structured and replicable, multimodal approach offers the ability to address multiple dysfunctions presented by the adult patients with ADHD. Through a problem-solving approach, patients are encouraged to identify a main problem, such as having low self-acceptance, always being late for work, being distracted at work, not finishing tasks, poorly managing time, always missing deadlines, and being angry all the time, which in turn, increases their motivation to find solutions. The participation of the whole group in this process enhances trust and cohesion. During the group discussions, the similarity of all the problem presentations and of all the difficulties, gives each patient a sense of legitimacy and decreases their sense of failure, thereby motivating them toward success. Some of the peers are able to facilitate viable solutions. As patients reach improved awareness through the mindfulness and cognitive exercises, they are able to reflect on their distorted core beliefs and challenge their irrational thoughts. Through the use of time management tools, they are also better able to organize their programs and spaces, and to implement success. The patients' participation in peer discussions addressing transgenerational interaction patterns helps to facilitate reflection on family dynamics, as participants critically analyze their genograms, recognizing familial dysfunctions and their contribution to forming emotional difficulties.

The group work favors problem identification, positive reinforcement and modeling, while the group discussions facilitate anger expression, communication training, as well as assertiveness training. The mindfulness and CBT exercises are also most effective, as they foster awareness, relaxation, organization and success in implementing new solutions to the problems. At the end of the group therapy program, the patients express a significant appreciation

of this intervention, attributing it to having enhanced their self-esteem and self-acceptance, and having helping them gain better control over their tendency toward self-blame.

This paper describes this particular treatment method in great detail in order to help other clinicians implement it into their own clinical and research work, and to facilitate the reproducibility of the results in any validation studies that may be based on this method. The specific interventions described above build on each other in a meaningful way. It is particularly important to maintain the sequence of the delineated approaches, as they are the result of intensive team reflection.

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Date of publication: 17.11.2014

Table 1. DSM-IV-TR Criteria for Diagnosing ADHD

<p>Diagnostic Criteria for Attention-Deficit/Hyperactivity Disorder Either A or B:</p> <p>A. Either (1) or (2):</p> <p>(1) Six or more of the following symptoms of inattention have been present for at least 6 months to a point that is disruptive and inappropriate for developmental level:</p> <p>Inattention</p> <ul style="list-style-type: none">a) Often does not give close attention to details or makes careless mistakes in schoolwork, work, or other activitiesb) Often has trouble keeping attention on tasks or play activitiesc) Often does not seem to listen when spoken to directlyd) Often does not follow instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)e) Often has trouble organizing activitiesf) Often avoids, dislikes, or doesn't want to do things that take a lot of mental effort for a long period of time (such as schoolwork or homework)g) Often loses things needed for tasks and activities (e.g., toys, school assignments, pencils, books, or tools)h) Is often easily distractedi) Is often forgetful in daily activities <p>(2) Six or more of the following symptoms of hyperactivity-impulsivity have been present for at least 6 months to an extent that is disruptive and inappropriate for developmental level:</p> <p>Hyperactivity</p> <ul style="list-style-type: none">a) Often fidgets with hands or feet or squirms in seatb) Often gets up from seat when remaining in seat is expectedc) Often runs about or climbs when and where it is not appropriate (adolescents or adults may feel very restless)d) Often has trouble playing or enjoying leisure activities quietlye) Is often "on the go" or often acts as if "driven by a motor"f) Often talks excessively <p>Impulsivity</p> <ul style="list-style-type: none">g) Often blurts out answers before questions have been finishedh) Often has trouble waiting one's turni) Often interrupts or intrudes on others (e.g., butts into conversations or games) <p>B. Some symptoms that cause impairment were present before age 7 years</p> <p>C. Some impairment from the symptoms is present in two or more settings (e.g., at school/work and at home)</p> <p>D. There must be clear evidence of significant impairment in social, school, or work functioning</p> <p>E. The symptoms do not happen only during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder. The symptoms are not better accounted for by another mental disorder (e.g., Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder)</p>
